STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	125056	A. Building B. Wing	05/20/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hale Makua Health Services	1540 Lower Main Street Wailuku, HI 96793

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42871 Based on record reviews and interviews, the facility failed to prevent Resident, (R)34's alleged sexual abuse by R52, and did not monitor R52's sexual behavior, and failure to report R52's behavior to R52's physician. The facility failed to protect R34, who was a vulnerable resident from sexual abuse. This deficient practice has the potential to affect all vulnerable residents residing in the facility. Findings include: On 05/18/22 at 11:59 AM, reviewed the completed Event Report dated 05/13/22 retrieved from the Aspen Complaints/Incidents Tracking System (ACTS), intake number 9520. The Event Report was completed by the facility's Administrator and described an alleged sexual abuse incident between R34 and R52 that occurred on 05/12/22 at 12:06 AM. The physician was notified on 05/12/22. R52 exposed his genitalia to R34 and R34 grabbing it. The certified nursing assistant (CNA) observed this incident, separated the residents, and reported it to the supervising nurse. On 03/29/22, R34 was assessed to have a Brief Interview for Mental Status (BIMS) score of 7, which means that that R34's mental status is severely impaired. On 04/12/22, R52 was assessed to have a BIMS score of 11, which means he is moderately impaired. On 05/20/22 at 06:27 AM, R52's electronic medical record (EMR) was reviewed. R52 is a [AGE] year old resident admitted to the facility on [DATE] for unspecified dementia with behavioral disturbance. The progress notes for 04/20/22 to 05/20/22 were read. Nursing staff documented on 05/10/22 at 10:10 PM that R52 was observed to be looking into a female resident's room with a female resident lying in bed. Another nursing staff documented on 05/11/22 at 1:30 PM that R52 was staring at the same female resident while she sat in her wheelchair. R52 then started to shows (sic) his private to the res. R52 was then advised by the nurse to go back to his room. The nurse further documented that R52 came back again to park his wheelchair next to [the same resident] .but without showing his private. On 05/11/22 at 9:29 PM, nursing documented that R52 angled his wheelchair so that he was very close to resident, nearly touching her. R52 was redirected by the nursing staff to which he moved his wheelchair away from the resident and went to his room. There was no documentation by the nursing staff that R52's physician was notified of R52's sexual behavior. On 05/20/22 at 06:53 AM, R34's EMR was reviewed. R34 is a [AGE] year old resident readmitted to the facility on [DATE] after suffering a stroke. A Lack of Capacity Determination for Surrogate Making was signed by R34's physician on 05/16/19. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0600 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 05/20/22 at 07:01 AM, the facility's policy and procedure, Comprehensive Abuse Policy and Prevention Program, was reviewed. 3) Prevention: . The facility will assume for the safety of a resident deemed incapable of decision making that the resident is incapable of declining to participate in the sexual act or lacks the ability to understand the nature of the sexual act and therefore, the act would constitute sexual abuse. On 05/20/22 at 08:45 AM, the Social Worker (SW) and the Director of Nursing (DON) were interviewed in the conference room. SW stated that R52 was moved to a different room approximately one week prior to the alleged sexual abuse incident. R52 was moved closer to the nursing station for increased monitoring by staff. SW stated that the facility was unsure if R52 was fixated on a certain female resident. SW confirmed that R34's husband was her surrogate decision maker. The DON stated that the physician was not notified of R52's escalating sexual behavior. On 05/20/22 at 11:00 AM, the facility's policy on Behavior Assessment and Monitoring, revised April 2007, was reviewed. Under Assessment, . 2. The nursing staff will identify, document, and inform the physician about an individual's mental status, behavior, and cognition including: a. Onset, duration and frequency of problematic behavior or changes in behavior, cognition, or mood .; Monitoring 1. If the resident is being treated for problematic behavior or mood, the staff and physician will obtain and document ongoing reassessment of changes (positive or negative) in the individual's behavior, mood, and function .

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0609 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Timely report suspected abuse, neglect, or theft and report the results of the investigation to proper authorities. 42871 Based on record reviews and interviews, the facility failed to report to the proper authorities an alleged sexual abuse incident involving Resident (R)34 and perpetrated by R52. This deficient practice has the potential to affect all residents in the facility, who may suffer from alleged violations of abuse. Findings include: On 05/18/22 at 11:59 AM, reviewed the completed Event Report dated 05/13/22 retrieved from the Aspen Complaints/Incidents Tracking System (ACTS), intake number 9520. The Event Report was completed by the facility's Administrator and described an alleged sexual abuse incident between R34 and R52 that occurred on 05/12/22 at 12:06 AM. R52 exposed his genitalia to R34 and R34 grabbing it, (cross reference to F600 free from abuse and neglect). The physician and resident's representatives were notified of this incident on 05/12/22. The State Agency (SA) was notified on 05/13/22. The police and Adult Protective Services (APS) were not notified. On 05/20/22 at 07:01 AM, the facility's policy and procedure, Comprehensive Abuse Policy and Prevention Program was reviewed. 7) Reporting/responding: Abuse Policy requirement: The facility must report alleged violations related to mistreatment, exploitation, neglect or abuse . and report the results of all investigation to the proper authorities within prescribed timeframes. Procedures: . The Administrator or designee with report to the state survey agency and others (police, APS, OIG, AG, etc) will be notified as mandated by regulation and as needed alleged abuse (this includes sexual assault). On 05/20/22 at 08:45 AM, the social worker (SW) and director of nursing (DON) were interviewed in the conference room. The SW confirmed that the sexual abuse allegation was not reported to the police and APS.

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42160 Based on observations, interviews, and record reviews, the facility failed to provide quality care in accordance with the professional standards of practice, the comprehensive person-centered care plan, and the resident's choices for three (3) residents (Resident (R)11, R38, and R68) sampled. R11 treatment of pain, restorative nursing care to prevent contractures, footdrop, and a loss of range of motion, and care plan was not implemented to provide quality of care. Findings include: R11 was admitted to the facility on [DATE] with diagnosis that include: Parkinson's disease; Dementia; high blood pressure; diabetes type two, and chronic kidney disease. Review of R11 annual minimum data set (MDS) with an assessment review date (ARD) of 02/22/22 documented in Section G. R11 requires extensive assistance (resident involved in activity, staff provides weightbearing support) for bed mobility. R11's pain was not managed according to professional standards of care. During an interview with R11 on 05/17/22 at 1:39 PM, the resident stated that he has chronic pain and ask staff for medication, but the medication doesn't always help. Review of R11's electronic medical record (EMR) on 05/19/22 at 3:05 PM documented R11's care plan did not include the implementation of non-pharmacological interventions to treat, minimize, or reduce the resident's pain prior to administering pharmacological interventions. Review of R11's physician orders documented the resident was prescribed three pain medications. Acetaminophen 650 milligram (mg) suppository rectally for mild to moderate pain; Ibuprofen 600 mg as needed three times a day; and Hydrocodone-Acetaminophen 7.5-325 mg every 6 hours (diagnosis: pain). However, the medication orders for Ibuprofen 600 mg and Hydrocodone-Acetaminophen 325 mg did not specify which medication should be administered in relation to the resident's pain rating, 0-10 (10 being the worst). As a result of this, the resident's pain rating of 9 could be undertreated with Ibuprofen or a pain rating of 2 (minimal pain) could be over treated with Hydrocodone-Acetaminophen 325 mg. Review of the facility's policy and procedure on pain management documented the facility will identify non-pharmaceutical interventions effective in the past (massage, acupuncture, etc.) and other nursing measures such as low light, soft music, repositioning, and conversation can be used, and the resident will be reassessed for response to treatment and response documented. In four random observations between 05/17/22 at 1:37 PM and 05/20/22 at 09:30 AM, R11 was laying supine in bed. No wedges or pillows were implemented to off-load the resident from being in one position during observations. During one observation on 5/19/22 at 11:45 AM, a pillow was placed under R11's knees to float the resident's heels, however, R11's heels were in direct contact with the bed. A follow up observation at 2:11 PM, noted R11 remained in the same position with his heels still in touch with the bed. Review of the resident's care plan documented R11 is dependent on staff for all needs due to diagnosis and require staff assistance for repositioning every two hours and when needed when in bed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 05/20/22 at 9:20 AM, conducted concurrent observations, record review, and interview with Nursing Supervisor (NS)1. Observed R11 laying in bed and inquired about R11's footdrop due to no documentation of it in the resident's record. NS1 stated that previously R11 did not have footdrop. NS1 informed the Nurse Practitioner (NP)1, who did an assessment on R11 and verbally confirmed to NS1 and this surveyor, R11 did not previously have footdrop and currently has footdrop. Inquired if R11 is receiving services for the prevention of contractures, footdrop, and range of motion as R11 was not seen with devices applied for the prevention of contractures or footdrop. R11's electronic medical record (EMR) revealed that R11 received physical therapy from 02/20/22 to 03/18/22 and was ordered restorative nursing program (RNP) on 04/24/22. On 04/24/22 at 09:05 AM, NS1 documented in a progress note that nursing received the physical therapy discharge summary with recommendations for RNP 6x/week for passive range of motion (PROM) and bed mobility. The NP agreed. Surveyor inquired why it took a month for R11 to receive the orders for RNP. The NS1 provided progress notes and explained that on 04/11/22 at 12:16 PM, NS1 documented a conversation with occupational therapy requesting clarification on RNP for R11 because no program was specified. Review of the RNP logs that document R11 name was handwritten onto the Restorative Nurse Aide (RNA)1's log the week of April 18 to 24. R11's name did not appear on the RNA1's log for the following three weeks (April 25-May 1; May 2-8; May 9-15) and the resident's name was handwritten for the week of May 16-22. Review of the log documented R11 did not receive any services or PROM from the RNA1. Surveyor conducted an interview with the RNA1 on 05/20/22 at 12:10 PM. RNA1 confirmed R11 did not receive RNP services since the resident was admitted to the program. RNA1 could not indicate whether the resident refused services or was offered services. RNA1 stated that there are just too many residents and not enough staff to assist all the residents on the RNP. RNA1 stated he/she has not provided PROM for R11. 38870 Cross reference to F688 Increase/prevent a decrease in ROM and mobility. 1) Resident (R)38 is a [AGE] year-old female with a diagnosis that includes hemiparesis (weakness on one side of the body) that affects the right dominant side. She has dementia with behavioral disturbance, and contracture of the right hand. R38 does not speak English and was heard yelling out very loud on a few occasions during the survey. Surveyor made six random observations between 05/17/22 at at 08:48 AM and 05/19/22 at 11:26 AM, R38 did not get out of bed. Surveyor did not observe any passive or active range of motion being provided to R38. On 05/19/22 at 02:52 PM surveyor spoke with the restorative nurse aide (RNA) and asked if she has a daily RNA schedule? She stated that they just bring the residents to her who are in the restorative nursing program. She also stated that she is the only one covering for now. Surveyor reviewed the list of residents on the schedule for the last three weeks. R38 had not received any restorative care. When the surveyor asked the RNA if she is receiving services she said, no, that one always refuses. On 05/20/22 at 09:43 AM surveyor reviewed R38 electronic medical record (EMR). Care plan reviewed. Risk for skin breakdown. I am at risk for skin breakdown due to . the need for extensive assistance with bed mobility. Approach includes . Staff to assist me with turning at each round and as needed. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Category: ADL functional/ rehabilitation potential. Approach includes . Turn me with the assist of one to two staff. Transfer me with the assist of one to two staff. Get me out of bed daily. Turn and reposition R38 in bed and chair every round. Encourage R38 to have physical activity, mobility, and ROM. On 05/20/22 at 12:56 PM surveyor interviewed the charge nurse (CN) 5. Surveyor asked CN5 what is the expectation for the staff and how is he ensuring that R38 and the other residents are being turned and repositioned. He responded that if the individual can't turn and requires assistance, then nursing staff should be turning them every two to three hours. Nursing progress note reviewed: Root cause analysis by Intra disciplinary team (IDT) for found on floor (FOF) on 5/8/22 at 1755. Recommend physical therapy (PT) referral for bilateral lower extremity (BLE) strength and transfers. On 05/20/22 at 12:56 PM surveyor interviewed the charge nurse (CN) 5. Surveyor asked the CN5 what is the expectation for the staff and how is he ensuring that she and the other residents are being turned and repositioned. He responded that if the individual can't turn and requires assistance, then nursing staff should be turning them every 2-3 hours. 2) Resident (R)68 is a [AGE] year-old female admitted to the facility on [DATE] for rehabilitation services for strengthening and mobility following a fracture of the right femur and hospital discharge. Eight random observations were made between 05/17/22 at 9:30 AM to 05/20/22 at 11:30 AM. Surveyor only observed R68 out of her bed one time in her wheelchair on 05/17/22. On 05/17/22 at 12:26 PM, surveyor asked certified nurse aide (CNA)6 how many residents he takes care of. He shared that he takes care of 10 residents and works with another CNA, there is one licensed nurse. When asked how if there are enough staff to ensure the residents are adequately cared for, he replied that staffing has been difficult at times due to staff calling out sick but today is good. On 05/17/22 at 12:55 PM, surveyor noted resident R68 sitting in a wheelchair at the bedside in her room eating lunch. There were signs posted outside the door that stated to see the nurse before going in. Registered nurse (RN)6 explained that the resident is on droplet precautions because she was exposed to a staff member who tested positive for COVID-19. On 05/18/22 at 9:45 AM, Surveyor reviewed the care plan for R68. I am at risk for skin breakdown related to (R/T) impaired mobility, incontinence of bowel and bladder. Approach: Elevate heels when I am in bed. Assist me with turning. Encourage me to be in chair or walking as tolerated. Activities of daily living (ADL) assistance: I require extensive to total assistance with ADLs, due to recent surgery, bilateral upper and lower weakness. Approach: Assist with transfers as needed. encourage participation in therapy/ ADLs to my maximum potential. On 05/19/22 at 10:43 AM during a discussion with the director of nursing (DON) who stated that the residents who are extensive assist should be turned every two to three hours, but two hours is preferable. (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	On 05/20/22 at 12:52 PM during a discussion with Registered Nurse (RN)5 if R68 is receiving restorative therapy. RN responded that therapy works with R68 throughout the day. They round with her. When surveyor asked how the nursing staff are ensuring the residents are being turned and repositioned, he responded that if the individual can't turn and requires assistance, then nursing staff should be turning them every two to three hours. Surveyor explained that several observations were made during the survey process and R68 was observed to be in bed in the same position most of the day.

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42871 Based on observations, record review, and interviews, the facility failed to protect Resident (R)27 from any more potential falls by not ensuring that: 1) the Care Sense fall prevention alarm placed on R27's bed was engaged to alert staff if R27 got out of bed unassisted, 2) other staff were aware that R27 was able to disengage from her clothing a personal tab alarm used for fall prevention, 3) R27's care plan was updated and individualized to recognize R27's capability of unclipping her personal tab alarm from her clothing and her refusals to wear the alarm, and 4) staff were following facility policy and procedures. These deficient practices places R27 in at a high of injury due to her medical diagnosis and history of falls. This has the potential to affect residents in the facility who are prone to falls, have a medical diagnosis that makes them prone to fractures, and use fall prevention alarms. Finding includes: On 05/18/22 at 12:41 PM, reviewed the completed Event Report dated 02/07/22 retrieved from ACTS, intake number 9330. R27 suffered a right upper arm fracture with decreased movement of her shoulder after having an unwitnessed fall in the bathroom. R27 was identified as being at high risk for falls and injury due to her history of falls and diagnosis of osteoporosis (weakened bones that are susceptible to fracture). On 05/19/22 at 09:19 AM, R27 was observed to be sitting up at the edge of the bed in her room, facing the doorway looking out of her room, both feet on the floor, her personal alarm was not clipped to her clothing. A minute later, CNA3 passed by R27's room, looking at R27, but not entering her room. At 10:58 AM, R27 was observed to be lying in bed, sitting up. Activities assistant (AA)8 went into R27's room and provided her with water and left. At 11:00 AM, State Agency (SA) observed that R27's personal alarm was still not clipped to her clothing. On 05/19/22 at 11:01 AM, concurrent observation and interview were done with Licensed Practical Nurse (LPN)11 in R27's room. LPN11 confirmed that R27's personal alarm was not clipped to her shirt during the morning and attempted to clip it to R27's shirt, but R27 refused. LPN11 stated that R27 had been in and out of bed all morning, going to the bathroom using her walker. LPN11 instructed R27 that she needed to clip the personal alarm to her shirt for her safety, but R27 continued to refuse. On 05/19/22 at 11:10 AM, an interview was done with RN5. RN5 stated that R27 was a high fall risk, and she gets out of bed without calling. R27 has a personal alarm that needs to be attached to her and that staff try to check on R27 at least once every hour or more within the hour. RN5 did not receive any notification from other staff that R27 had unclipped her personal alarm. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	On 05/19/22 at 11:18 AM, an interview was done with CNA6. CNA6 stated that R27 takes off the clip from the personal alarm and clips it to the bed sheet or chux pad and probably had been off since R27 returned from the dining room after eating breakfast. R27's assigned CNA, CNA2, is aware of R27 being able to remove the clip of the personal alarm off her person and that CNA2 frequently checks on her. On 05/19/22 at 11:30 AM, a concurrent observation and interview was done with CNA2 at R27's bedside. CNA2 confirmed that R27 removes the clip from her personal alarm because that it is her personal choice, but stated that R27 had another fall prevention alarm, Care Sense, on her mattress to alert staff if R27 got out of the bed. CNA2 uncovered the Care Sense alarm control at the foot of R27's bed and noted that it was unplugged. CNA2 stated that the Care Sense alarm needed to be plugged in for it to work and prevent R27 from getting out of bed unassisted and proceeded to place the plug into the Care Sense alarm. CNA2 stated that she checked the alarm at the beginning of her shift at 06:30 AM and the electrical connection was plugged and doesn't know when it became disconnected. On 05/19/22 at 1:00 PM, R27's EMR was reviewed. R27 is a [AGE] year old resident admitted to the facility on [DATE] for unspecified dementia without behavioral disturbance and age-related osteoporosis. A progress note written by nursing on 05/23/21 at 10:45 PM, revealed that R27 had an initial unwitnessed fall in the facility on 05/23/21 at 10:15 PM. The progress note also stated that the Care Sense and personal tab alarm were used, but that R27 was able to remove the clip from the personal tab alarm. A progress note written by nursing on 05/24/21 at 8:34 PM, revealed that R27 sustained a left rib fracture after the fall. A root cause analysis of R27's fall was done and documented on 05/26/21 at 11:07 AM by nursing. The capability of R27 to remove her personal tab alarm was not addressed. Progress notes documented by nursing on 01/19/22 at 09:03 PM to 01/26/22 at 09:17 PM revealed that a trial run of not utilizing the Care Sense alarm was done. R27 sustained another fall on 02/04/22 at 4:28 PM where she suffered a right upper arm fracture. R27's fall prevention alarms were re-instituted after this second fall. On 05/19/22 at 04:02 PM, a concurrent record review and interview were done with the DON in the conference room. DON stated that was not aware of R27 being able to unclip her personal alarm from her person and that it would the responsibility of the staff to inform the nurse in charge if it was unclipped or if R27 refused to use it. While reviewing R27's care plan, it was confirmed that R27's capability to unclip her personal alarm and R27's refusals to wear the alarm, were not identified on the care plan. The DON further verbalized that R27's care plan should be personalized and updated to recognize R27's individual and specific behaviors with her personal tab alarm. On 05/20/22 at 10:30 AM, reviewed the facility's Fall Prevention and Management policy with effective date of 05/01/21. B. Dynamic Treatment Plan 1. Specific interventions based on results of fall assessments and individual resident's preferences. The interdisciplinary team members must address: . c. Resident's daily routines d. Mental status/behaviors. On 05/20/22 at 12:45 PM, the facility's policy on Resident Alarms Copyright 2020 was reviewed. Under Policy Explanation and Compliance Guidelines: 1. The use of alarms do not eliminate the need for adequate supervision of the resident ., . 4. Evaluation and analysis of risk a. The interdisciplinary team shall analyze each resident's unique risks and medical symptoms to determine the root cause(s) of each risk , and . 5. Implementation of interventions a. Resident-directed approaches shall be implemented in accordance with the resident's needs, goals, and preferences .